Meeting Date	**30 January 2020**	**Agenda Item**	**4.4**
Report Title	**Board Assurance Framework (BAF)**		
Report Author	Jacqui Maunder, Interim Head of Compliance		
Report Sponsor	Pam Wenger, Director of Corporate Governance		
Presented by	Pam Wenger, Director of Corporate Governance		
Freedom of Information	Open		
Purpose of the Report	The purpose of this report is to provide the Health Board with an update on the work to review and update the Health Board's Board Assurance Framework (BAF) document.		
Key Issues	• The development of the Board Assurance Framework (BAF) has been agreed by the Board and is owned by the Accountable Officer and the Board, • The Director of Corporate Governance is the lead Executive with responsibility for the delivery of the BAF, • The Audit Committee has a key role in overseeing the development of the BAF, and • Meetings have been held with the relevant Executive Directors and managerial leads (e.g. Nursing, Health & safety) to discuss content and obtain updated information to populate the BAF. • The Executive team reviewed the updated BAF at its meeting 13 November 2019. • The Audit Committee endorsed the updated BAF at its meeting 21 November 2019 recognising the document will continually evolve. • The BAF will be monitored by the Risk Management Group in tandem with the Health Board Risk Register (HBRR).		
Specific Action Required ***(please choose one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
	☐	☐	☒	☐
Recommendations	Members are asked to: • **NOTE** the progress on the development of the Board Assurance Framework (BAF), acknowledging that it is a work in progress and will be continually updated			

BOARD ASSURANCE FRAMEWORK (BAF)

1. INTRODUCTION

The purpose of this report is to provide the Health Board with an update on the work to review and update the Health Board's Board Assurance Framework (BAF) document.

2. BACKGROUND

It is essential that there is an effective and efficient framework in place to give sufficient, continuous and reliable assurance on organisational stewardship and the management of the major risks to organisational success and delivery of improved, cost effective, public services. Understanding the sources of assurance and their scope means internal audit can focus most effectively on the riskier areas. The structured mapping of assurances is one of the fundamental steps in building an assurance framework.

An effective assurance framework:

- Provides timely and reliable information on the effectiveness of the management of major strategic risks and significant control issues

- Facilitates escalation of risk and control issues requiring visibility and attention by senior management, by providing a cohesive and comprehensive view of assurance across the risk environment

- Provides an opportunity to identify gaps in assurance needs that are vital to the organisation, and to plug them (including using internal audit) in a timely, efficient and effective manner

- Can be used to raise organisational understanding of its risk profile, and strengthen accountability and clarity of ownership of controls and assurance thereon, avoiding duplication or overlap

- Provides critical supporting evidence for the production of the Governance Statement

- Can clarify, rationalise and consolidate multiple assurance inputs, providing greater oversight of assurance activities for the Board/Audit & Risk Assurance Committee in line with the risk appetite; and

- Facilitates better use of assurance skills and resources.

The original Board Assurance Framework was developed following discussion within the Board and guidance outlined within the Good Governance Guide for NHS Wales Boards (2014), Academi Wales; and the joint BAF workshop held with NHS Wales Audit Committee Chairs, the Wales Audit Office (WAO) and the NHS Wales Board Secretaries network in January 2018.

In 2018 the Director of Corporate Governance undertook a governance stocktake and areas of focus for 2018-19 were captured within a Governance Work Programme for 2018-19. The Audit Committee endorsed an agreed template for the BAF in 2018, however, due to the challenges in terms of the risk management system and process, the Audit Committee agreed to pause the development of the BAF whilst work progressed on the risk management process to develop an updated Health Board Risk Register (HBRR). The new HBRR was approved by the Audit Committee in early 2019.

Since then work has been undertaken to develop the BAF influenced through feedback from the Audit Committee and internal audit. The revised document reflects good practice, is evidence led through business intelligence and feedback from the Executive Team and reflects the actions required from the internal audit feedback on the BAF.

The updated BAF has been compiled to take account of the good practice identified in the Care Quality Commission's (CQCs) Quality report for the University Hospitals Bristol NHS Foundation Trust[1] which stated that the Board Assurance Framework in place provided clear alignment between strategic priorities and risks within the organisation, and clear evidence of ward to board, to ward feedback loops and escalation with a strong basis in the governance systems in place within the trust.

The revised SBUHB BAF outlines the health board risks and a summary of focus areas for internal audit and external inspection has been further developed to provide additional assurance.

2.1 Developing the BAF

The Board Assurance Framework has been developed in partnership with the Executive Directors and their teams and has been updated to map risks from the Health Board Risk Register (HBRR) to the specific enabling objectives. In addition, unit risks emanating from the Service Delivery Units (SDU's) have also been mapped to each enabling objective to provide a ward to board view of operational risks. There is further work to do on reviewing and finalising the list of operational risks, and the next update of the Board Assurance Framework will include the operational risks once validated by the Units which will include the operational risks which could have an impact on the delivery of the agreed corporate objectives.

The work undertaken to strengthen and develop the BAF includes:

- Updated to reflect feedback from the Audit Committee and Internal audit recommendations to include unit risks, assurance ratings etc
- Mapping of SBUHB's enabling objectives, and one associated primary risk allocated per objective instead of several
- Cross referenced with the updated Health Board Risk Register, November 2019
- Cross referenced with the internal audit progress update – Audit Committee September 2019
- Reference to external inspection reports have been added (where known)
- Cross referenced with the Annual Plan 2019-2020 and Clinical Services Plan
- Cross referenced with the Annual Plan quarterly returns to the Performance & Finance Committee – Q1 & Q2
- The adequacy of assessment barometer indicator has been given based on a number of different factors, including level of risk, level of assurance etc
- Meetings have been held with the relevant Executive Directors and communication with managerial leads (e.g. Nursing, Health & safety etc) in September & October 2019 to discuss content and obtain updated information

[1] https://www.cqc.org.uk/sites/default/files/new_reports/AAAG3535.pdf

2.3 Operationalising the use of the Board Assurance Framework

The Audit Committee endorsed the BAF for ongoing use within SBUHB in November 2019 recognising that it is a developing document. The BAF will be taken forward as set our below:

- The Health Board risks and unit risks will be validated to ensure a full and accurate map across to strategic and frontline operational risks, in discussion with the Head of Patient Experience, Risk & Legal Services
- Individual Directors will be asked to provide additional information to further populate the document to ensure it continues to align with the Quarterly updates provides against the SBUHB annual plan
- The level of risk and an assessment of the adequacy of assurances will be undertaken and included in the next update on the Board Assurance Framework
- The BAF will be monitored by the Risk Management Group in tandem with the Health Board Risk Register (HBRR).
- Every 6 months sections of the BAF to be monitored by relevant Board committees and Management Groups to ensure risk management of the delivery of the strategic objectives.
- Every quarter the Executive Team will review full BAF prior to presentation to Audit Committee.
- Every 6 months the BAF will be presented to the Board for Assurance.

The Internal audit forward plan of business for 2019-2020 included an audit on the BAF commencing in December 2019.

3 GOVERNANCE AND RISK ISSUES

a) Board Assurance Framework (BAF)

The populated BAF is attached at *Appendix 1.* It is important to note that the BAF will continue to be updated so it remains a live assurance tool with exception reports provided to key Committee meetings of the Board as appropriate.

Whilst the Audit Committee will on behalf of the Board oversee the BAF, it is not proposed that the Audit Committee spend time discussing precise wording or risk scores but rather focus on whether the framework meets the Board's needs and whether the most significant risks and assurance arrangements are captured. This work will be supported by the existing arrangements in place that assign risks to key Committees of the Board as appropriate.

It is acknowledged that some risks are Unit specific and that these have and will from time to time be escalated onto the organisational risk register because of the extreme nature of the risk.

c) Link to Audit programmes

A key source of assurance comes from internal, clinical and external audit reports, including Wales Audit Office, Royal College reviews, Delivery Unit reviews and these will be captured in the overall framework to support the Board in the triangulation of issues and assurances required.

Internal Audit
The annual internal audit programme is risk based. The BAF will need to take into account audit activity undertaken and particularly audits resulting in limited or no assurance ratings. It's also important to recognise positive assurance.

Clinical Audit & Effectiveness
The Audit Committee handbook recommends stronger alignment of clinical audit activity as a key source of internal assurance. Clinical Audit plans are now dominated by the Welsh Government National Clinical Audit & Outcome Review Plan (NCA&ORP), although this is complemented by Unit audits. Clinical Audit should more prominently as a key source of Board Assurance. .

External Audit : The Wales Audit Office (WAO)
Undertake a number of performance audits during each year – some are part of a mandated national programme and others are those that are UHB specific – these are informed through previous findings and discussion with the Executive and Audit Committee.

It's important also to note the role of Healthcare Inspectorate Wales and other Regulators e.g. Health & Safety Executive; South Wales Fire & Rescue, along with that of the Community Health Councils, all of whom undertaken planned and unannounced inspection and review work.

4 FINANCIAL IMPLICATIONS
There are no direct financial implications arising from the recommendations in this report.

5 RECOMMENDATIONS

Members are asked to:

- **NOTE** the progress on the development of the Board Assurance Framework (BAF), acknowledging that it is a work in progress and will be continually updated

Governance and Assurance		
Link to Enabling Objectives ***(please choose)***	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☒
	Co-Production and Health Literacy	☐
	Digitally Enabled Health and Wellbeing	☐
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☐
	Excellent Staff	☐
	Digitally Enabled Care	☐
	Outstanding Research, Innovation, Education and Learning	☐
Health and Care Standards		
(please choose)	Staying Healthy	☐
	Safe Care	☒
	Effective Care	☒
	Dignified Care	☒
	Timely Care	☒
	Individual Care	☒
	Staff and Resources	☒

Quality, Safety and Patient Experience

Ensuring the Board and its Sub-Committee(s) makes fully informed decisions is dependent on the quality and accuracy of the information presented and considered by those making decisions. Informed decisions are more likely to impact favourably on the quality, safety and experience of patients and staff.

Financial Implications

There are no direct financial implications arising from this report.

Legal Implications (including equality and diversity assessment)

Ensuring the Board has an effective and evolving Board Assurance Framework (BAF) that supports the Board in delivering the current one year plan, is an essential component of the Board's Governance arrangements going forward.

Staffing Implications

The development of the BAF will require a significant amount of work from the Executive Team and their teams to ensure that the process of mapping is undertaken and that this framework meets the needs of the Board. Progress on the development of the BAF is slower than anticipated due to the pause to await the updated Health Board Risk register, and there was no resource to support this work until May 2019.

Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)

The Act requires the Health Board to think more about the long term, how we work better with people and communities and each other, look to prevent problems and take a more joined up approach with partners. There will be long term risks that will affect both the delivery of services, therefore, it is important that you use these five ways of working (Long Term Thinking, Prevention, Integration, Collaboration and Involvement) and the wellbeing goals identified in the Act in order to frame what risks

the Health Board may be subject to in the short, medium and long term. This will enable The Health Board to take the necessary steps to ensure risks are well managed now and in the future.	
Report History	Board Development Session 22 February 2018 Executive Team 5 March 2018 Audit Committee March 2018 Executive Board 22 August 2018 Executive Board 12 September 2018 Audit Committee 20 October 2018 Risk Management Group 4 July 2019 Audit Committee 15 July 2019 Executive Team 13 November 2019 Audit Committee 21 November 2019
Appendices	Appendix 1 - Board Assurance Framework (BAF)

BOARD ASSURANCE FRAMEWORK (BAF)
2019-2020

Last updated 8 November 2019

Swansea Bay University Health Board Control Framework

High Quality Care

Controls:
Evidenced within:
- Annual Plan
- Commissioning
- Annual Quality Objectives
- intentions and plans
- Capital and Estates Strategy
- Quality Impact Assessment protocol
- Equality Impact Assessment

Assurance: gained via:
- Quality and Safety Committee
- Divisional Quality Groups
- Senior Leadership Team
- Annual Quality Report
- Annual Report and Annual Governance Statement
- Chairs Reports
- Visits and Inspections

Performance Management

Controls:
- Objectives and Appraisals
- Performance targets
- Performance Dashboards and monthly reporting
- Regular Performance and Quality reports
- Concerns and Patient Experience Reports
- Serious Incident Reporting

Assurance: gained via:
- Unit Boards, Service/Ward levels
- Escalation arrangements
- Audits, visits
- Executive Director and Senior Leadership Team meetings
- Quality and Safety, Finance and Audit Committees
- Internal/External Audits

Risk Management

Controls:
- Risk management strategy and Policy
- Board Assurance Framework
- Corporate Risk Register
- Divisional Risk Register
- Reports to the Board, Senior Leadership Team and sub committees
- Policies and Procedures
- Scheme of Delegation

Assurance: gained via:
- Delivery Boards, Service/Ward levels
- Escalation arrangements
- Internal/External Audits, visits
- Executive Director and Senior Leadership Team meetings
- Quality and Outcomes, Finance and Audit Committees

Levels of Assurance

VISION AND STRATGEIC PRIORITIES

First Line
Operational

- Organisational structures – evidence of delegation of responsibility through line Management arrangements
- Compliance with appraisal process
- Compliance with Policies and Procedures
- Incident reporting and thematic reviews
- Compliance with Risk Management processes and systems
- Performance Reports, Complaints and Patient Experience Reports, Workforce Reports, Staff Nursing Report, Finance Reports

Second Line
Risk and Compliance

Reports to Assurance and Oversight Committees

- Audit Committee
- Finance Committee
- Quality and Safety Committee
- Remuneration Committee
- Risk Management Group, Health and Safety Groups etc.

Findings and/or reports from inspections, Friends and Family Test, Annual Reporting through to Committees, Self-Certification

Third Line
Independent Assurance

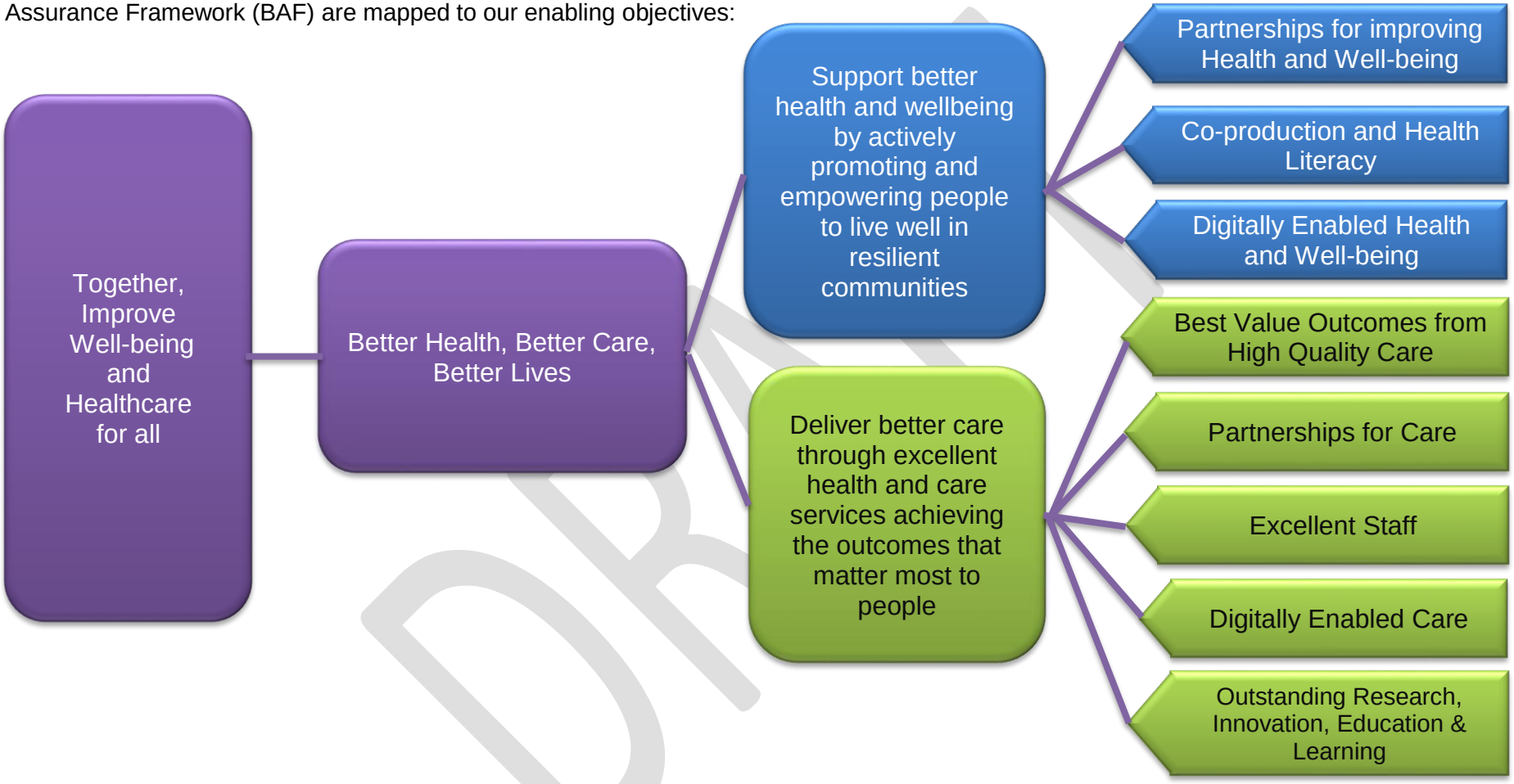
- Internal Audit Plan
- Wales Audit Office (WAO) (Structured Assessment)
- External Audits (e.g. Annual Accounts and Annual Report)
- Health Inspectorate Wales (HIW) Inspections
- Visits by Royal Colleges
- External visits and accreditations
- Independent Reviews

REGULATORS

EXTERNAL AUDIT

Aligning Board Assurance with Swansea Bay University Health Board (SBUHB) Strategy

The Swansea Bay University Health Board (SBUHB) strategy is outlined in the figure below and all risks identified for inclusion on the Health Board Assurance Framework (BAF) are mapped to our enabling objectives:



Board Assurance Framework Summary Against SBUHB Enabling Objectives –

	Q1	Q2
Partnerships for improving Health and Well-being		
Failure to reduce inequalities and deliver improvements in population health for our population		
Co-production and Health Literacy		
Failure to establish and maintain effective relationships with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working		
Digitally Enabled Health and Well-being		
Failure to have IM&T systems in place which do not meet the requirements of the organisation		
Best Value Outcomes from High Quality Care		
Risk that the Health Board will be unable to maintain the quality of patient services and financial sustainability		
Partnerships for Care		
Failure to establish and maintain effective relationships with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working		
Excellent Staff		
Failure to have an appropriately resourced, focussed, resilient workforce in place that meets service requirements.		
Digitally Enabled Care		
Failure to have IM&T systems in place which do not meet the requirements of the organisation		
Outstanding research, Innovation, Education and Learning		
Failure that the Health Board will not be able to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.		
Embedding effective corporate governance		
Failure to meet statutory obligations in relation to corporate governance, including health & safety, infection control, etc. which could result in breaches in standards and other failures leading to significant patient harm, financial penalties and regulatory intervention.		

Key	Improvement	Deterioration	No Change

Approach to Risk Assessment - Risk scoring = consequence x likelihood

	Likelihood				
Consequence	**1 Rare**	**2 Unlikely**	**3 Possible**	**4 Likely**	**5 Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

1 - 3	Low risk
4 - 9	Moderate risk
8 -15	High risk
16 - 25	Very High risk

The current scores for principal risks are summarised in the following heat map.

	Likelihood				
Consequence	**1 Rare**	**2 Unlikely**	**3 Possible**	**4 Likely**	**5 Almost certain**
5 Catastrophic					
4 Major					
3 Moderate					
2 Minor					
1 Negligible					

Assurance Ratings

Substantial assurance - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

Reasonable assurance - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.

Limited assurance - The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

No assurance - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved.

Levels of Assurance – 1st, 2nd & 3rd

▲	Substantial Assurance	▲	Satisfactory Assurance
▲	Reasonable assurance	▲	Limited assurance

1. Enabling Objective : Partnerships for improving Health and Well-being

Principal Risk : Failure to reduce inequalities and deliver improvements in population health for our population

Health Board Risks	**Unit/Operational Risks**
• HBRR 11 – Healthcare Model for Ageing Population • HBRR 15 – Population Health Improvement	•

Executive Lead: Director of Public Health | **Assuring Committee:** Quality & Safety Committee

Key Controls	Form of Assurance	Levels of Assurance 1st	2nd	3rd	Gaps in Control	Gaps in Assurance	Actions Agreed for any gaps in control or assurance	Adequacy	Current Risk Rating	Direction of Travel
1.1 Population Health Improvement • Public Health Strategy and work plan • Internal Audit Management Plan • Strategic Immunisation Group • MMR Task & Finish group • Childhood Imms Group; • Primary Care Influenza Group • Support from PHW Health Protection • Public Health measures are included in the Performance Report • Strategic Immunisation group	• Progress against the Public Health Work plan • Immunisation action plan • Regular reports to the Quality and Safety Committee • Performance Reports • Strategic Outline Case submitted to Welsh Government for Integrated Wellness Centres in Swansea and Neath Port Talbot areas • Local smoking cessation services • Improve uptake of childhood immunisations • Improve flu vaccination uptake rates for children, people with chronic conditions and people over 65. • Evaluating campaign activity • Nutrition Skills for Life Programme to be expanded • Exercise and Lifestyle pilot • Area Planning Board	▲ ▲ ▲ ▲ ▲ ▲ ▲ ▲ ▲ ▲	▲ ▲	▲	All childhood immunisation targets below trajectory with the exception of school immunisation targets. .	Internal Audit report Vaccination & Immunisation (ABM-1819-012) Limited Assurance	Scrutiny by internal audit, raise awareness, encourage uptake, target population. Co-production work with the public. A national catch up campaign will be undertaken in 2020 for MMR SBUHB need to review data accuracy between primary care and child health system to be able to reliably call under immunised children unless some action is taken to cleanse the data regularly. Minimum 90% uptake childhoods imms, MMR vaccination in teenage population, HPV / Teenage booster. Improve uptake of Men ACWY in primary care.			

1.2 Annual Plan Priorities • Annual Plan/Integrated Medium Term Plan (IMTP) • **Neighbourhood Approach** - the Neighbourhood Approach Project Plan • **Suicide and self-harm** -multi-sectorial Suicide and Self-Harm Prevention action plans • **Community resilience** - Health and housing Take an asset based approach to build community resilience and social connectedness. • **Health and Housing** - Working with partners, targeting at risk groups to improve Health and Housing including environmental factors, flexible housing, homelessness and future proofing. • **Health in all Policies** - Developing Health in All Policies Framework with partners developing enhanced green and blue spaces using Green Infrastructure mapping.	• Regular reports to the Quality and Safety Committee • Quarterly Performance Reports • Bi-monthly Highlight Reports to West Glamorgan Adult Transformation Board. Regional Partnership Board • Actions from devolved Critical Incident Group now being managed by Swansea and NPT Community Safety Partnership. Highlight Reports bi-monthly to West Glamorgan Area Planning Board. • Multi-agency Building Safe & Resilient Communities Partnership established, with Senior Leadership and Operational groups. • Social Care, Health & Housing Group established to develop 3-5 year Strategy. Bi-monthly Highlight Reports to Integrated Transformation Board. • Estates Reports	▲	▲ ▲ ▲ ▲ ▲ ▲		None identified	None identified	Quarterly monitoring reports to the Performance & Finance Committee. Bi-monthly Highlight Reports to Clinical Services Plan Programme Board. Further reporting to the Regional Partnership Board. Quarterly Highlight Report to Swansea and NPT Public services Board. Operational groups reports to Senior Leadership Group bimonthly. In turn this reports into NPT PSB quarterly. Further reporting to the Regional Partnership Board. Strategy will be co-produced using the West Glamorgan Co-production group.			

2.Enabling Objective: Co-production and Health Literacy

Principal Risk : Failure to establish and maintain effective relationships with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working

Corporate Risks	**Unit Risks**
• No risks identified	• No risks identified

Executive Lead: Director of Public Health | **Assuring Committee:** Quality & Safety Committee

Key Controls	Form of Assurance	Levels of Assurance 1st	2nd	3rd	Gaps in Control	Gaps in Assurance	Actions Agreed for any gaps in control or assurance	Adequacy	Current Risk Rating	Direction of Travel
2.1 Wellness Centre • Integrated Wellness Centres in Swansea and Neath Port Talbot areas	• Strategic Outline Case submitted to Welsh Government for Integrated Wellness Centres in Swansea and Neath Port Talbot areas		▲		None identified	None identified	None Identified			
2.2 Healthy Behaviours: • Local Smoking Cessation service in place • Childhood immunisation programme • Programme for flu vaccination uptake rates for children, people with chronic conditions, over 65's and staff • Programme for healthy eating for under 3's • Roll out of training health literacy and MECC • Exercise and Lifestyle pilot	• Improved uptake of childhood immunisations • Improved flu vaccination uptake rates for children, people with chronic conditions and people over 65. • Evaluation campaign activity • Nutrition Skills for Life Programme to be expanded • Area Planning Board	▲ ▲ ▲ ▲		▲	None identified	Internal Audit report Vaccination & Immunisation (ABM-1819-012) Limited Assurance	Minimum 90% uptake childhoods imms, MMR vaccination in teenage population, HPV / Teenage booster. Improve uptake of Men ACWY in primary care			
2.3 Substance and Alcohol misuse • Multi-agency Project Team established to develop a revised 3 year Dual Diagnosis Strategy.	• A review of all Substance Misuse Services being undertaken across the region, overseen by the Area Planning Bard.		▲		None identified	None identified	Dual Diagnosis Strategy to be signed off by Area Planning Board. New Strategy will be co-produced using the West Glamorgan Co-production group. Service review and proposed new service model to be signed off by Area Planning Board.			

3.Enabling Objective : Digitally Enabled Health & Well-being	
Principal Risk: Failure to have IM&T systems in place which do not meet the requirements of the organisation	
Corporate Risks	**Unit Risks**
• HBRR 27 – Sustainable Clinical Services for Digital Transformation • HBRR 36 – Electronic Patient Record • HBRR 45 – Discharge Information	•
Executive Lead: Chief Digital Officer	**Assuring Committee:** Performance & Finance Committee

Key Controls	Form of Assurance	Levels of Assurance 1st	2nd	3rd	Gaps in Control	Gaps in Assurance	Actions Agreed for any gaps in control or assurance	Adequacy	Current Risk Rating	Direction of Travel

3.1 Overarching
• Digital Strategy
• Digital Strategic Outline Plan
• IMTP
• Draft workforce plan
• Transformation Portfolio Board
• Digital Programme Group
  ○ Programme Boards
  ○ Project boards
• Digital Service Management Group
  ○ iCAB and Change control
  ○ System User Groups
  ○ National SMBs
• Information Governance Group
  ○ Information Governance Peer Group
  ○ Data Quality Peer Group
• Clinical Reference Group
• Investment Benefits Group
• Capital Management Group
• Digital SDU meetings
• Digital Business meeting
  ○ Risk meeting
  ○ DPRG
  ○ Finance meeting
• Clinical Services Plan
• West Glamorgan Regional Digital Transformation Group
• National Digital Governance arrangements
  ○ NIMB
  ○ IPAD
  ○ WIAG
  ○ WTISB
  ○ WTSB
• Digital Inclusion Charter
	• SIRO Reports		▲		• Capital plan to deliver programmes of work have yet to be signed off
					• Impact of Boundary Change on ability to deliver/requirements not yet fully known
					• WG funding process for future years still to be confirmed
					• Impact of national architecture and governance reviews not yet known.
					• Capability and capacity to deliver needs to be assessed and gaps resourced
					• Lack of certainty over future funding streams makes planning and implementation difficult/less effective
						• Alignment to revised NWIS and WG structure
						• Process for future WG digital funding allocations not known
							• Sign off IMTP including project milestones and funding.
							• Confirm representation on National Digital Governance arrangements
							• Continue to develop timely business cases			

	• Programme Board updates	▲								
	• Highlight and escalation reports	▲								
	• Change control	▲								
	• National reporting against the plan			▲						
	• IMTP reporting against the plan		▲							
	• National Architecture Review			▲						
	• National Governance Review			▲						
	• ICO audits			▲						
	• Project evaluation and closure reports	▲								
	• Major incident reports	▲								
	• Audit committee reports		▲							
	• Chair's assurance report			▲						
	• IG audits		▲							
	• Staff Forums	▲								
	• Performance reviews	▲								
	• Project initiation documentation and review process	▲								
	• Systems highlight and exception reports	▲								
	• Transition to service reporting	▲								
	• Prince 2 project management process	▲								
	• ITIL service management	▲								
	• Risk register	▲								
	• Information Asset Register	▲								
	• Internal Audit reports		▲							
	• Penetration testing	▲								
	• Incidents and complaints reporting	▲								

	• User evaluations • Digital inclusion steering group	▲ ▲								
3.2 Patient & Citizen Empowerment • Swansea Bay Patient Portal (previously PKB) • Outpatient SMS Text Reminder • Patient appointment booking • PROMS • Digital Inclusion • Virtual Clinics	• Clinical Services plan • Clinical Reference Group • New Digital Strategic Outline Plan and Strategy to support the first phase of the road map for the delivery of the digital plan in the new Health Board approved by the Health Board. • Capital Prioritisation Group for the HB considers digital risks for replacement technology which is fed into the annual discretionary capital plan • Investment and Benefit Group process provides scrutiny to ensure Digital resources required are considered for all projects • Informatics prioritisation process has been introduced to ensure requests for digital solutions are considered in terms of alignment to the strategy objective, technical solutions and financial implications • Working closely with WG to identify funding streams to support investment in digital including the approval of the Informatics Strategic Outline Plan • Implementation Plan for solution provision set out within the IMTP and progress monitored through Digital and HB governance processes eg Digital Transformation Board and Transformational Portfolio Board • Project Boards established for all significant projects • Capital Management Group monitors capital expenditure position against plan.	▲ ▲ ▲ ▲	▲ ▲ ▲		• Lack of certainty over future funding streams makes planning and implementation difficult/less effective • Patient/Citizen Forums not in place to implement Swansea Bay Patient Portal (previously Patients Know Best (PKB))	• Dedicated role to champion digital inclusion not in place or funded • Digital platform for capture of PROMS not yet agreed. Currently piloting different methods • Service leadership of patients communications model not established	Continue to work with new service to implement SBPP (PKB) within Swansea Bay. Evaluation delayed until Q 1 2020/21. Seek IBG approval for 1 year extension of contract. Gain approval from Senior Leadership Team to offer SBPP (PKB) to all Swansea Bay staff Work with Outpatients modernisation group to agree way forward for patient communications model. Sign off IMTP including project milestones and funding.			

3.3 Integrated Health Care • GP Test Requesting & Results Reporting (Pathology) • GP Test Requesting & Results Reporting (Other Disciplines) • Community Care (WCCIS) • West Glamorgan Regional Digital Strategy • Eye care referrals/electronic record • Dental referrals • Choose Pharmacy	• Support Integrated Care via Digital Partnerships and transformation, working together with Local Authorities to roll out WCCIS to maximise benefit in terms of information sharing, integrated record keeping and mobilisation. • West Glamorgan Regional Digital Strategy Group • Implementation Plan for solution provision set out within the IMTP and progress monitored through Digital and HB governance processes eg Digital Transformation Board and Transformational Portfolio Board • Project Boards established for all significant projects • Regional working Boards established to monitor integrated working • Capital Management Group monitors capital expenditure position against plan. •	▲	▲	▲	• Investment required supporting the delivery and operational costs of the Digital strategy. • Reliance on NWIS for delivery of the solution for a fully electronic patient record • Funding streams for implementation of WCCIS are not finalised	None identified.	Finalise Full Business Case and Deployment Order for Community Nursing Proposal (Deployment order complete) Q2 Milestone Updated: Continue to work on Full Business Case for IBG Q3 2019/20. Continue to work on Deployment Order. Sign off IMTP including project milestones and funding.			
3.4 Information & Business Intelligence (BI) • BI strategy • Natural Language Processing (NLP) with SAIL • SNOWMED CT • TRINETX (R&D) • PROMS (Value) • National Data Resource & Clinical Data Repository	• BI strategy, implementation plan and infrastructure • Implementation Plan for solution provision set out within the IMTP and progress monitored through Digital and HB governance processes eg Digital Transformation Board and Transformational Portfolio Board • Project Boards established for all significant projects • Capital Management Group monitors capital expenditure position against plan.	▲	▲ ▲ ▲		• Capability and capacity to deliver needs to be assessed and gaps resourced .	National solution currently being tested so no assurances at this stage the solution will be suitable or on implementation timescales.	Discussions are ongoing in regard to the National WEDS systems Sign off IMTP including project milestones and funding.			

3.5 Streamlined Business Processes • Patient Note Tracking (RFID) • Digital Dictation & Voice Recognition • Intranet & Business efficiency core • Office 365 • Single sign on smart card strategy	• Temporary retention and destruction plans are in place. Ward protocols and audits have been rolled out across sites. • All records must be documented and risk assessed in the Information Asset Register (IAR) • RFID project being implemented and will change the way records are filed and release storage capacity. • Policy and Procedures, Protocols and audits • Information Asset Register • Reports to the Information Governance Group and Audit Committee • SIRO Annual Report to the Board • Implementation Plan for solution provision set out within the IMTP and progress monitored through Digital and HB governance processes eg Digital Transformation Board and Transformational Portfolio Board • Project Boards established for all significant projects • Capital Management Group monitors capital expenditure position against plan.	▲ ▲ ▲ ▲ ▲ ▲	▲ ▲	▲	• Investment required supporting the delivery and operational costs of the Digital strategy. • Impact of the Infected Blood Enquiry on the Health Boards ability to destroy notes. • Office 365 roll out plan still to be determined and reliant on NWIS/ funding.	None identified.	Health Records Department will work with HB colleagues to develop a case for improved storage solution both for paper and digitally. Business case for digital dictation to be produced across the HB Secure funds from WG to facilitate roll out of Office 365 Sign off IMTP including project milestones and funding.			
3.6 Digital Enabling Programmes • Digital infrastructure and cloud • Mobilisation and Devices • Cybersecurity • Information Governance • Digital Capacity and Capability (Workforce and Citizens)	• Digital transformation programme • SIRO Annual Report to the Board • Capital Prioritisation Group for the HB considers digital risks for replacement technology which is fed into the annual discretionary capital plan • Investment and Benefit Group process provides scrutiny to ensure Digital	▲	▲ ▲	▲	• Capital plan to deliver programmes of work have yet to be signed off • Impact of Boundary Change on ability to deliver/requirements not yet fully known • WG funding process for future years still to be confirmed • Impact of national architecture and governance reviews not yet known.		Work with Capital finance an WG to agree resourcing arrangements. Work with CTM on the business case to implement boundary change disaggregation actions			

	resources required are considered for all projects • Head of cyber security role established and appointed to. • Service Management Group established to manage existing Digital services • Information Governance Group in place to monitor progress of implementation of Information Governance plan • Health Board have signed the Digital Inclusion charter and are working to establish a plan to deliver • Digital workforce plan in process of being developed as part of the 2020-2023 IMTP process. • Implementation Plan for solution provision set out within the IMTP and progress monitored through Digital and HB governance processes eg Digital Transformation Board and Transformational Portfolio Board • Capital Management Group monitors capital expenditure position against plan. • Joint Executive Team for Boundary Change to consider Digital implications of disaggregation of services going forward	▲ ▲ ▲ ▲	▲ ▲ ▲				Sign off IMTP including project milestones.			

4.Enabling Objective: Best Value Outcomes from High Quality Care		
Principal Risk : Risk that the Health Board will be unable to maintain the quality of patient services and financial sustainability		
Corporate Risks	**Unit Risks**	
• HBRR 1 – Tier 1 Targets • HBRR 4 – Infection Control Targets • HBRR 11 – Ageing Population • HBRR 13 – Environment of HB Premises • HBRR 16 – Access to Planned Care • HBRR 37 – Information Led Decisions • HBRR 39 – Approved IMTP – Statutory Compliance • HBRR 41 - Fire Safety Compliance • HBRR 42 – Financial Plan • HBRR 43 – DOLS Authorisation & Compliance with Legislation • HBRR 48 – Child & Adolescent Mental Health Services (CAMHS) • HBRR 49 Trans-catheter Aortic Valve Implementation (TAVI) Service • HBRR 50 – Access to Cancer Services • HBRR 57 – Non-Compliance with Home Office Controlled Drug Licensing requirements • HBRR 58 – Ophthalmology Clinical Capacity • HBRR 61 – Paediatric Dental GA Service Parkway • HBRR 63 – Screening for Fetal Growth Assessment in line with Gap and Grow • HBRR 64 – Health & Safety Infrastructure • HBRR 66 – Unacceptable delays in access to SACT treatment in Chemotherapy Day Unit • HBRR 67 – Clinical risk-target breeches in the provision of radical radiotherapy treatment		•

Executive Lead: Chief Operating Officer, Executive Medical Director & Director of Nursing & Patient Experience					**Assuring Committee:** Quality and Safety Committee				
Key Controls	**Form of Assurance**	**Levels of Assurance**			**Gaps in Control**	**Gaps in Assurance**	**Actions Agreed for any gaps in control or assurance**	**Adequacy**	**Current Risk Rating**	**Direction of Travel**
		1st	**2nd**	**3rd**						
4.1 Operational Performance • TI priority measures summary dashboard and monthly performance report • Unit Performance Reviews • Unit Board meetings reviewing national targets • Remedial action plans in place for each red or amber indicator. • Daily Health Board wide conference calls/ supported by revised HB escalation process, business continuity and major incident plans. • Increased reporting as a result of targeted intervention status. • Weekly calls with Units to support delivery and monitor performance.	• Regular reporting to Executive Team, Executive Board and Health Board/Quality and Safety Committee. • Monthly performance and finance meetings between executive team and service directors. • Executive monitoring/support to achieve improvement plans on a weekly basis. • Detailed performance information reviewed through unit performance meetings and unit boards. • Weekly Service director/COO meeting to ensure implementation of	▲	▲		• Bed utilisation audit undertaken in 2018 to support USC system redesign programme in NPT and Swansea. • The findings of this audit have resulted in the development of the West Glamorgan Hospital to Home transformation programme which has a formal project management structure.		**Unscheduled Care and Stroke:** Action: Working with social care partners to implement the West Glamorgan Hospital to Home transformation service model aimed at delivering more patient care at, or closer to, home, reducing the number of patients awaiting discharge planning in hospital. This programme encompasses the findings of DU			

• Modest investment package agreed to support additional activity to increase capacity. • Supported by Service Improvement Team and through the Patient flow service optimisation work stream of the recovery and sustainability programme. • Winter Plan in place for the Health Board • In relation to planned care the Health Board's profile for numbers of patients waiting over 36 weeks at the end of 2018-2019 was at its lowest level since April 2014, with significant improvement in the longest waiting times (a reduction of 500 patients over the course of the year). • Treat in Turn tools operationalised • Cohort tools operationalised • Support from Cwm Taf Morgannwg UHB re backfill • Support from NPTH re additional orthopaedic waiting lists • Theatre group considering how to increase throughout through theatres • Additional staff training and recruitment (along with short term agency) to increase resilience of Morriston elective theatre • Investment in additional validation to eradicate duplications and review long waiting patients • Creation of a Gold Command to oversee improvements in Ophthalmology • Additional investments with WG – approx. £500K to cover a number of local delivery unit initiatives to reduce overall numbers of follow ups by at least 15% by the year end. • Stroke work ongoing around the development of a Hyper Acute Stroke Unit – a Joint partnership development with Hywel Dda UHB to provide more immediate, focused and rehabilitative care in	improvement actions and monitor performance. • Monthly Health Board USC improvement board chaired by COO to oversee delivery of improvement plans. • Monthly Quality and Delivery meetings with WG and DU. • Morriston delivery unit plan reflects recommendations from external support. • External capacity/demand modelling undertaken in community services to inform sustainable capacity solutions/ system shifts • Monthly performance reports at Performance and Finance Committee and the Board focussing on TI areas. • The 2018-2019 targets agreed with Welsh Government were exceeded • NHS Wales Delivery Unit support provided in house and also support to the RTT meetings • COO/SDU meetings (unscheduled care) • Stroke Delivery Board • Planned care delivery board • Outpatient Transformation Board • WG quality & delivery meetings • National fora, e.g. Planned Care Board/Outpatient Modernisation, Stroke Implementation Group etc	▲ ▲ ▲ ▲ ▲ ▲ ▲		▲ ▲ ▲ ▲ ▲ ▲ ▲			report on the Right Place Right care review. Implementation of the ambulance handover plan agreed between the HB, WAST and NCCU. Implementation of the USC plan and HB winter plan. Action: Promotion of FAST, continued development of TIA services, establishing a Thrombectomy pathway through WHSSC. **Planned Care** Action: Improve Theatre efficiency and utilisation including ENT/ orthopaedics access to Singleton and Neath Port Talbot theatres.- The plan to establish all day ENT operating at Singleton Hospital in Q1 has been revise as it is not possible to achieve this by September due to, in the main, anaesthetics pressures. The revised plan is to target an October start and the plan and milestones will be revised to reflect this. Action: General Surgery access to			

the first 72 hours of a stroke patients care.							Singleton theatres to utilise for routine and high activity capacity - The plan to establish one all day General Surgery operating list at Singleton Hospital and one all day list at Morriston has been revised. Morriston are on track to start in September. However it has been agreed not to commission the Singleton list. The plan and future milestones will be revised to reflect this.			
4.2 Clinical Standards & Audit Performance • National Clinical Audit Programme • NICE Guidance	• Reports to the Clinical Audit group • Unit Clinical audits • Delivery unit Clinical audit group	▲ ▲	▲		• IA report on Clinical Audit & Assurance (ABM-1819-022) – Limited Assurance • IA report Data Quality: Delayed Follow ups (ABM-1819-028) • Health Inspectorate Wales (HIW) - Kris Wade Report • Health Inspectorate Wales (HIW) - Dyfed Road Health Centre • Health Inspectorate Wales (HIW) - West Cross Lane Dental Surgery • Health Inspectorate Wales (HIW) - Neath South Community Mental Health Team – The Forge Centre • Audit committee report on Ambulance handover July 2018. • Cwm Taf UHB Maternity Review In March 2019 the RCOG published a report concerning the maternity services at CTMUHB and Welsh Government sought assurance	Schedule of national, HB mandated and unit audits needs to factor in re-audits to monitor improvements made (plan, do check cycle) Introduce a maturity matrix to map progress and assess areas for further development.	Introduce an oversight group to oversee the structure and schedule of clinical audits. Including the management of local audits at unit/department level. Gather business intelligence through benchmarking with other leading NHS organisations on audit schedules and clinical monitoring processes.			

					on the maternity service provision in place across the seven HB's in Wales. SBUHB submitted a report to Welsh Government advising a review was being undertaken.					
4.3 Infection Control Targets (HBRR4) • Infection Control Sub Group • Bug stop quality improvement programme • Infection control team support the clinical teams for issues relating to infection control • ICNet information management system for infections is in place	• Regular monitoring on infection rates at Quality and Safety Committee • IA report Infection Prevention & Control July 2019 (1920-019) – Reasonable Assurance • Regular monitoring through TI meetings with Welsh Government • Policies, procedures and guidelines in place • Regular reporting through internal processes • Additional staff in post including permanent infection control doctor, decontamination lead and assistant director of nursing	▲ ▲ ▲	▲	▲ ▲	None identified	ICNet provides information linked with PAS relating to patients who have been inpatients since the connection was made therefore additional manual records are maintained by the infection control team creating additional work and some duplication.	Further focused work will be on environmental decontamination and infection control needs to be considered for all refurbishment and new works to ensure our hospitals provide suitable facilities for infection control.			
4.4 Quality & Safety • Annual Plan/IMTP • Clinical Service Plan • Regional Clinical Services Plan • Reports to Board & Quality & Safety Committee on: ○ Primary & Community Care ○ Unscheduled Care & stroke ○ Planned Care ○ Cancer ○ Mental Health & learning & Development ○ Women & Children & Young People ○ Older People ○ Quality, Safety & Patient Experience • Quality & Safety Assurance Framework • Quality & Safety Assurance Group	• Quarterly annual plan reporting to Performance & Finance Committee • Reports to the Quality & Safety Committee • Reports to the Monthly Quality & Safety Assurance Group meetings • Monthly Health and Care Standards Steering group meetings and Unit/Directorate quarterly updates on the HCS standards • Health and Care Standards mini scrutiny panel • Policies, procedures and guidelines in place • Development of transitional care Unit at Singleton • Crisis pathway reviewed	▲ ▲ ▲ ▲ ▲	▲		• IA Report World Health Organization (WHO) Checklist (1920-021) – July 2019 Limited Assurance • Health Inspectorate Wales (HIW**) -** Kris Wade Report • Health Inspectorate Wales (HIW) **-** Dyfed Road Health Centre • Health Inspectorate Wales (HIW**) -** West Cross Lane Dental Surgery • Health Inspectorate Wales (HIW) **-** Neath South Community Mental Health Team – The Forge Centre • Audit committee report on Ambulance handover July 2018.		The Quality & Safety Assurance Framework will be presented to the Quality & Safety Committee 12 December 2019 and will be formally launched in 2020.			

• Quality Improvement panel • Health and Care Standards Annual Self-assessment	and in place for crisis team within the HB. • Discussion around the development of adolescent facilities within acute and CAMHS • Unscheduled care, development of one port of entry for all CYP. Business plan being developed and project team convened. • Continuing care funding CYP • HCAI - agreement for addition resource to focus on community acquired HCAIs will assist in the prevention programme and reduce rates and in turn admissions to hospital relating to HCAIs. The gap around this is that there is currently no resource but this is being addressed and will be in place for the next financial year. There is a considerable amount of work underway but this is captured as part of the TI and ICC work streams. • IA Report Falls Prevention & Management (1920-020) September 2019 – Reasonable Assurance • IA Report Medicines Management (incl CD's & incidents) June 2019 – Reasonable Assurance • IA Report Hospital Sterilization & Disinfection Unit (HSDU) (1920-037) – Reasonable Assurance Sept 2019 • IA Report MH&LD Unit Governance (1920-034) Reasonable Assurance • IA Report Cardiac Services Risk Management (1920-035) Reasonable Assurance • Annual Quality Statement	▲ ▲ ▲ ▲ ▲		▲ ▲ ▲ ▲ ▲	• Cwm Taf UHB Maternity Review In March 2019 the RCOG published a report concerning the maternity services at CTMUHB and Welsh Government sought assurance on the maternity service provision in place across the seven HB's in Wales. SBUHB submitted a report to Welsh Government advising a review was being undertaken.					

5. Enabling Objective: Partnerships for Care

Principal Risk : Failure to establish and maintain effective relationships with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working

Corporate Risks	**Unit Risks**
• HBRR 11 – Healthcare Model for Ageing Population • HBRR 15 – Population Health Improvement	• 1797 – WAST delay in handover • 1894 – WAST escalation delay • 1418 – Patient Safety CAMHS Safeguarding

Executive Lead: Director of Strategy — **Assuring Committee:** Health Board

Key Controls	Form of Assurance	Levels of Assurance 1st	2nd	3rd	Gaps in Control	Gaps in Assurance	Actions Agreed for any gaps in control or assurance	Adequacy	Current Risk Rating	Direction of Travel

5.1 Regional Clinical Services Plan
• Develop a Regional Clinical Services Plan for the South West Region (HDDUHB and SBUHB)
• National Endoscopy Group
• Endoscopy feasibility plan 2019/2020
• Orthopaedics action plan 2019-2020
• Vascular Surgery Steering Group
• Dermatology Regional Planning Group
• Operational plan focusing on regional eye on-call service
• regional cellular pathology service
	• Strategy, Planning & Commissioning Group meetings
	• Hywel Dda UHB and SBUHB agreed strategies
	• Meet the requirements of the National Endoscopy Group. Key elements will be included:
	  ○ 'Routine' endoscopy work
	  ○ Implications of changes to the FIT test/Bowel Screening
	  ○ Implications of the Single Cancer Pathway
	• Catheter labs funding agreed through WHSSC
	• Orthopaedics action plan 2019-2020 agreed by the Joint Regional Planning and Delivery Committee
	• implementation of the regional Limb at Risk Pathway
	• National Dermatology Peer Review
	• Dermatology Regional half-day workshop
		▲	▲	▲
				▲
				▲
				▲
				▲
					None identified.	None identified.	Develop a draft RCSP for agreement by the JRPDC in Quarter 2
							
							Implement and monitor agreed Endoscopy feasibility plan 2019/2020
							
							Planning work for replacement of 3rd catheter lab at Morriston in year 2 or 3
							
							Consideration of joint strategic direction and action plan for 2019/20 UPDATE: JRPDC has agreed orthopaedics will be planned through respective HBs Annual Plans/IMTPs			

6. Enabling Objective: **Excellent Staff**										
Principal Risk: Failure to have an appropriately resourced, focussed, resilient workforce in place that meets service requirements.										
Corporate Risks • HBRR 3 – Workforce Recruitment of Medical & Dental Staff • HBRR 51 – Compliance with Nurse Staffing Levels (Wales) Act 2016 • HBRR 62 – Sustainable Corporate Services					**Unit Risks** •					
Executive Lead: Director of Workforce & OD					**Assuring Committee:** Workforce & OD Committee					
Key Controls	**Form of Assurance**	**Levels of Assurance**			**Gaps in Control**	**Gaps in Assurance**	**Actions Agreed for any gaps in control or assurance**	**Adequacy**	**Current Risk Rating**	**Direction of Travel**
		1st	**2nd**	**3rd**						
6.1 Leadership, Culture & Staff Development • Workforce & OD Committee • Workforce & OD Framework • Workforce & OD Directorate • Staff recognition programme • Long Service Awards • Patient Choice awards • SBUHB Equality Plan • Leadership summits • Meet the Executive team events • PADR 85% target • Core skills training framework 85% target • Guardian service • Footprints and Bridges development training • Consultant development programme and access to Academi Wales Medical Leadership programme • Coaching strategy • Kings fund leadership development programme • Talent Management and Succession planning toolkits • SBUHB Apprentice academy • "Project Search" Swansea & Neath Port Talbot • Vocational training and engagement contracts – working with the public and third sector to engage communities. • Internal graduate scheme	• Updates to the Board, Board Development sessions and the Workforce & OD Committee • Quarterly updates on progress against the Workforce & OD Framework • Staff recognition event • Long Service Award ceremony • Patient Choice awards ceremony • SBUHB Equality Plan and equality objectives contributing towards achievement of the WBFG 2015. • Staff Networks – Women's, BAME, LGBT • Member of Stonewall Diversity Champions network • Sessions undertaken through the Kings fund leadership development programme • Leadership summits • Meet the Executive team events • Number of enquiries to the Guardian service	▲ ▲	▲ ▲ ▲		Capacity of the workforce & OD directorate, due to limited staff resource PADR – 85% target for completion, PADR training for staff Core Skills training framework – online statutory and mandatory training modules – 85% target		Business case for additional workforce & OD resource submitted to the Executive team for consideration 13 November 2019.			

• NHS Wales Talent Management Scheme with HEIW • Values Led Induction programme • Staff survey • Family and friends survey	• Number of Footprints and Bridges development training • Participants on the Consultant development programme and access to Academi Wales Medical Leadership programme • Participants on the SBUHB Apprentice academy • Vocational training and engagement contracts – working with the public and third sector to engage communities. • Internal graduate scheme • NHS Wales Talent Management Scheme with HEIW • Values Led Induction programme • Results of the Staff survey • Results of the Family and friends survey • Sickness absence rates • Number of employee relations cases • Staff retention rates									
6.2 Workforce Resourcing • Workforce & OD Committee • Workforce & OD Framework • Workforce & OD Directorate • Recruitment campaigns • Development of a Locum bank • Mentorship programme for new recruits • GP Fellowship Scheme • GP Retainer scheme • Exchange programmes with other countries • Nurse recruitment action plan • Welsh Student streamlining project • Nursing & Midwifery strategy • Nurse Staffing (Wales) Guidance • HCSW development for degree courses • Establishment of an internal transfer window • Primary Care focused nursing programme with Swansea University	• Updates to the Board and the Workforce & OD Committee • Quarterly reports on progress against the Workforce & OD Framework • Medical Recruitment Action plan • All Wales BPIO campaigns • Proactive recruitment through social media channels • Junior Doctor Welfare Officer proposal being developed • Enhanced induction process for overseas doctors • Participants on the Locum bank • Participants on the Mentorship programme for new recruits				Capacity of the workforce & OD directorate, due to limited staff resource Deanery Educational Contract – introduction of 1:11 rotas Pension scheme impact on workforce planning assumptions & impact of early pension related retirements Age of General Practice Nurses (GPN's) and risk of potential deficit due to retirement. High level of agency and locum staff	IA report Nursing Quality Assurance: Matron Checks (ABM-1819-027) attained limited assurance rating in 2018-2019. IA report Medical Locum Cover (Follow up) (ABM-1819-046)	Business case for additional workforce & OD resource submitted to the Executive team for consideration 13 November 2019. A rolling programme of recruitment underway. Participating in the November 2019 BAPIO recruitment round. DBS project is been rolled out, all staff who require a DBS check who do not have one recorded will be checked.			

• Career fairs for therapies and health science • Healthcare science framework • Physician Associate General Practice Internship Programme • Development of band 7 physician associate posts • E-Exit interviews • Participate in Single All Wales Staff Bank	• Explore F3 posts • Participants on the GP Fellowship Scheme • Participants on the GP Retainer scheme • Exchange programmes with other countries • Relationship with BMJ • Working with MEDACS to support recruitment of doctors • Nurse recruitment action plan • Welsh Student streamlining project • Number of Return to practice open evenings for nursing staff • Number of Regional nurse recruitment days • Nursing & Midwifery strategy • Nurse Staffing (Wales) Guidance • Number of Overseas nurse recruitment Europe, Philippines and plans for Dubai and India for those who are IELTS ready • HCSW development for degree courses • Requests to the internal transfer window • Primary Care focused nursing programme with Swansea University • Number of Career fairs for therapies and health science • Regular reporting on the Healthcare science framework • Develop advanced physiotherapist and occupational therapist roles • Work with WAST to devise Paramedic & Advanced Paramedic primary Care schemes						Utilise temporary funded capacity to meet immediate areas of risk. Continue to raise resourcing issue at corporate level and through committee governance arrangements.			

	• Physician Associate General Practice Internship Programme • Number of band 7 physician associate posts • Number of E-Exit interviews completed • Participate in Single All Wales Staff Bank • Extend bank operations to become multi-disciplinary • IA Report Nurse Staffing Levels Act (1920-041) – Reasonable Assurance August 2019									
6.3 Workforce Efficiency • Reduce Variable Pay • Efficient Staff Development • Reduce sickness absence • Staff Health & Well-being • Ensure Staff Operate at the top of their Licence • Right size staffing establishments	• Reports to the Board, Workforce & OD Committee and the Health & Safety Committee. • Workforce & OD framework • Occupational Health transformation programme • Staff Well-being and Advice and Support Service • Well-being champions • Training for Managers to use HSE Stress Management standards • Work with “Time to Change Wales" • Schwartz Centre Rounds® • Lighten up and Stress awareness sessions • Work with WG to develop the “In Work Support” service • Gold Corporate Health Standard • Flu immunisations rates for staff – target of 60% • Review of junior doctor rotas using Kendal Bluck analysis • E-job planning system and review of job plans • ED workforce plan in Morriston • “Locum on Duty” to introduce digital booking and approval				Welsh Government Agency cap Agency Nursing Framework contract Winter pressures Efficient rostering practices					

	• Nursing e-rostering system, with “Safecare” module to provide real time measures of patient acuity to ensure safe staffing levels • Review of ward manager role, therapies and health science managerial roles • Introduce round house model in urgent care out of hours services • Reviews of ward skills mix • Workforce change plan • Sickness absence audit • All Wales Managing Attendance at work policy • Cultural audit tool being developed based on Kings fund model • Health and well-being workshops for staff • Reports to the Local Partnership Forum (LPF).									
6.4 Shape of the Workforce • Long-term workforce & education plans • Multi-disciplinary teams in primary care • Re-profiling and developing non-registered workforce	• Reports to the Board, & the Workforce & OD Committee • Workforce & OD Framework • Annual Plan • Clinical Services plan • Workforce plans being developed on integrated Primary & Community Care Services and supporting the role of clusters • Reconfiguration of the roles of our major hospitals and the modernisation of service delivery • Career pathways for the unregistered workforce • Talent management and succession plans • Staff survey results									
6.5 Pay & Reward • Staff reward & recognition • Nationally agreed pay arrangements	• Reports to Board, Workforce & OD Committee, LPF and the Remuneration and Terms of Service Committee									

	• Workforce & OD Strategy • Incentivise bank arrangements to increase supply including weekly pay • Creative design of junior doctor rotas and roles to enhance recruitment • Explore establishment of a GP retainer scheme to encourage GP's to continue in practice post retirement • Multi-disciplinary bank									

6.6 Workforce & Organisational Development (OD) Function
• Workforce Capacity and Structure
• Digital Workforce Solutions
• Employee relations climate
• Deliver the Basics Brilliantly
• Establish effective governance structure
	• Reports to Board, Workforce & OD Committee and Audit Committee
	• Workforce & OD Forum
	• Workforce & OD Framework
	• Clinical Services plan
	• Organisational Change Strategy
	• Development of ESR
	• Business investment case for a digital workforce solution 2019-2022
	  ○ ESR E-rostering
	  ○ Job planning and employee relations software
	  ○ Locum on duty
	• Partnership working with staff side - Local Partnership Forum meetings
	• Local Negotiating Committee
	• Employee relations casework
	• Internal audit assessments and recommendations
	• Workforce and OD risk register and workforce related risk on the Health Board risk register
	• Workforce plans									

7. Enabling Objective : Digitally Enabled Care

Principal Risk: Failure to have IM&T systems in place which do not meet the requirements of the organisation

Corporate Risks	Unit Risks
• HBRR 27 – Sustained Clinical Services • HBRR 36 – Electronic Patient Record • HBRR 45 – Discharge Information • HBRR 60 – Cyber Security	

Executive Lead: Chief Information Officer

Assuring Committee: Performance & Finance Committee

Key Controls	Form of Assurance	Levels of Assurance 1st	2nd	3rd	Gaps in Control	Gaps in Assurance	Actions Agreed for any gaps in control or assurance	Adequacy	Current Risk Rating	Direction of Travel
7.1 Overarching • Digital Strategy • Digital Strategic Outline Plan • IMTP • Draft workforce plan • Transformation Portfolio Board • Digital Programme Group ○ Programme Boards ○ Project boards • Digital Service Management Group ○ iCAB and Change control ○ System User Groups ○ National SMBs • Information Governance Group ○ Information Governance Peer Group ○ Data Quality Peer Group • Clinical Reference Group • Investment Benefits Group • Capital Management Group • Digital SDU meetings • Digital Business meeting ○ Risk meeting ○ DPRG ○ Finance meeting • Clinical Services Plan • West Glamorgan Regional Digital Transformation Group • National Digital Governance arrangements ○ NIMB ○ IPAD ○ WIAG ○ WTISB ○ WTSB • Digital Inclusion Charter	• SIRO Reports • Programme Board updates • Highlight and escalation reports • Change control • National reporting against the plan • IMTP reporting against the plan • National Architecture Review • National Governance Review • ICO audits • Project evaluation and closure reports • Major incident reports • Audit committee reports • Chair's assurance report • IG audits • Staff Forums • Performance reviews • Project initiation documentation and review process • Systems highlight and exception reports • Transition to service reporting • Prince 2 project management process • ITIL service management • Risk register • Information Asset Register • Internal Audit reports • Penetration testing • Incidents and complaints reporting • User evaluations • Digital inclusion steering group	▲ ▲	▲ ▲ ▲ ▲	▲ ▲ ▲ ▲ ▲ ▲ ▲ ▲	• Capital plan to deliver programmes of work have yet to be signed off • Impact of Boundary Change on ability to deliver/requirements not yet fully known • WG funding process for future years still to be confirmed • Impact of national architecture and governance reviews not yet known. • Capability and capacity to deliver needs to be assessed and gaps resourced • Lack of certainty over future funding streams makes planning and implementation difficult/less effective	• Alignment to revised NWIS and WG structure • Process for future WG digital funding allocations not known	• Sign off IMTP including project milestones and funding. • Confirm representation on National Digital Governance arrangements • Continue to develop timely business cases			

7.2 Patient & Citizen Empowerment • Swansea Bay Patient Portal (previously PKB) • Outpatient SMS Text Reminder • Patient appointment booking • PROMS • Digital Inclusion • Virtual Clinics	• Clinical Services plan • Clinical Reference Group • New Digital Strategic Outline Plan and Strategy to support the first phase of the road map for the delivery of the digital plan in the new Health Board approved by the Health Board. • Capital Prioritisation Group for the HB considers digital risks for replacement technology which is fed into the annual discretionary capital plan • Investment and Benefit Group process provides scrutiny to ensure Digital resources required are considered for all projects • Informatics prioritisation process has been introduced to ensure requests for digital solutions are considered in terms of alignment to the strategy objective, technical solutions and financial implications • Working closely with WG to identify funding streams to support investment in digital including the approval of the Informatics Strategic Outline Plan • Implementation Plan for solution provision set out within the IMTP and progress monitored through Digital and HB governance processes eg Digital Transformation Board and Transformational Portfolio Board • Project Boards established for all significant projects • Capital Management Group monitors capital expenditure position against plan.	▲ ▲ ▲ ▲	▲ ▲ ▲ ▲	▲ ▲	• Lack of certainty over future funding streams makes planning and implementation difficult/less effective • Patient/Citizen Forums not in place to implement Swansea Bay Patient Portal (previously Patients Know Best (PKB))	• Dedicated role to champion digital inclusion not in place or funded • Digital platform for capture of PROMS not yet agreed. Currently piloting different methods • Service leadership of patients communications model not established	Continue to work with new service to implement SBPP (PKB) within Swansea Bay. Evaluation delayed until Q 1 2020/21. Seek IBG approval for 1 year extension of contract. Gain approval from Senior Leadership Team to offer SBPP (PKB) to all Swansea Bay staff Work with Outpatients modernisation group to agree way forward for patient communications model. Sign off IMTP including project milestones and funding.			
7.3 Integrated Health Care • GP Test Requesting & Results Reporting (Pathology) • GP Test Requesting & Results Reporting (Other Disciplines) • Community Care (WCCIS) • West Glamorgan Regional Digital Strategy • Eye care referrals/electronic record	• Support Integrated Care via Digital Partnerships and transformation, working together with Local Authorities to roll out WCCIS to maximise benefit in terms of information sharing, integrated record keeping and mobilisation. • West Glamorgan Regional Digital Strategy Group	▲		▲	• Investment required supporting the delivery and operational costs of the Digital strategy. • Reliance on NWIS for delivery of the solution for a fully electronic patient record		Finalise Full Business Case and Deployment Order for Community Nursing Proposal (Deployment order complete) Q2 Milestone Updated: Continue to work on Full Business Case for IBG Q3			

• Dental referrals • Choose Pharmacy	• Implementation Plan for solution provision set out within the IMTP and progress monitored through Digital and HB governance processes eg Digital Transformation Board and Transformational Portfolio Board • Project Boards established for all significant projects • Regional working Boards established to monitor integrated working • Capital Management Group monitors capital expenditure position against plan.	▲ ▲	▲ ▲		• Funding streams for implementation of WCCIS are not finalised		2019/20. Continue to work on Deployment Order. Sign off IMTP including project milestones and funding.			
7.4 Information & Business Intelligence (BI) • Theatres • Single Cancer Pathway • BI strategy • Natural Language Processing (NLP) with SAIL • SNOWMED CT • TRINETX (R&D) • PROMS (Value) • National Data Resource & Clinical Data Repository	• BI strategy, implementation plan and infrastructure • Implementation Plan for solution provision set out within the IMTP and progress monitored through Digital and HB governance processes eg Digital Transformation Board and Transformational Portfolio Board • Project Boards established for all significant projects • Capital Management Group monitors capital expenditure position against plan.	▲ ▲	▲ ▲		• Capability and capacity to deliver needs to be assessed and gaps resourced		Discussions are ongoing in regard to the National WEDS systems Sign off IMTP including project milestones and funding.			
7.5 Streamlined Business Processes • Patient Note Tracking (RFID) • Digital Dictation & Voice Recognition • Intranet & Business efficiency core • Office 365 • Single sign on smart card strategy	• Temporary retention and destruction plans are in place. Ward protocols and audits have been rolled out across sites. • All records must be documented and risk assessed in the Information Asset Register (IAR) • RFID project being implemented and will change the way records are filed and release storage capacity. • Policy and Procedures, Protocols and audits • Information Asset Register	▲ ▲ ▲ ▲ ▲			Investment required supporting the delivery and operational costs of the Digital strategy. Impact of the Infected Blood Enquiry on the Health Boards ability to destroy notes. Office 365 roll out plan still to be determined and reliant on NWIS/ funding.		Health Records Department will work with HB colleagues to develop a case for improved storage solution both for paper and digitally. Business case for digital dictation to be produced across the HB Secure funds from WG to facilitate roll out of Office 365 Sign off IMTP including project			

	• Reports to the Information Governance Group and Audit Committee • SIRO Annual Report to the Board • Implementation Plan for solution provision set out within the IMTP and progress monitored through Digital and HB governance processes eg Digital Transformation Board and Transformational Portfolio Board • Project Boards established for all significant projects • Capital Management Group monitors capital expenditure position against plan.	▲ ▲	▲ ▲	▲			milestones and funding.			
7.6 Hospital Patient Safety & Flow • Nursing documentation • Electronic prescribing (HPMA) • Electronic Patient Record (WCP) • Emergency Department (WEDS) • Critical Care • Patient Flow • Radiology & Imaging • Laboratory Information Network (LINC)	• Digital Transformation Programme • WPAS has been implemented in Morriston as an interim solution but does not provide all the additional functionality required. • Archive solution developed for Accent to allow access to historic data in case of failure • WEDs programme is still being progressed by NWIS • Rollout of ED WPAS at NPT (June 2019) • Reports to the Information Governance Group and Audit Committee • Performance review meetings with NWIS • Mobilising the workforce with digital technology through the national Mobilisation Policy. • Implementation Plan for solution provision set out within the IMTP and progress monitored through Digital and HB governance processes eg Digital Transformation Board and Transformational Portfolio Board • Project Boards established for all significant projects	▲ ▲ ▲ ▲	▲ ▲ ▲	▲ ▲ ▲ ▲	Current Emergency department (ED) systems are not fit for purpose	ED - National solution currently being tested so no assurances at this stage the solution will be suitable or on implementation timescales	Discussions are ongoing in regard to the National WEDS systems Use National Mobilisation Policy to support roll out pilots of mobile systems such as Nursing Documentation and e-Prescribing. Sign off IMTP including project milestones and funding.			

	• Capital Management Group monitors capital expenditure position against plan.									
7.7 Digital Enabling Programmes • Digital infrastructure and cloud • Mobilisation and Devices • Cybersecurity • Information Governance • Digital Capacity and Capability (Workforce and Citizens)	• Digital transformation programme • SIRO Annual Report to the Board • Capital Prioritisation Group for the HB considers digital risks for replacement technology which is fed into the annual discretionary capital plan • Investment and Benefit Group process provides scrutiny to ensure Digital resources required are considered for all projects • Head of cyber security role established and appointed to. • Service Management Group established to manage existing Digital services • Information Governance Group in place to monitor progress of implementation of Information Governance plan • Health Board have signed the Digital Inclusion charter and are working to establish a plan to deliver • Digital workforce plan in process of being developed as part of the 2020-2023 IMTP process. • Implementation Plan for solution provision set out within the IMTP and progress monitored through Digital and HB governance processes eg Digital Transformation Board and Transformational Portfolio Board • Capital Management Group monitors capital expenditure position against plan. • Joint Executive Team for Boundary Change to consider Digital implications of disaggregation of services going forward	▲ ▲	▲ ▲ ▲ ▲ ▲ ▲	▲ ▲ ▲ ▲	• Capital plan to deliver programmes of work have yet to be signed off • Impact of Boundary Change on ability to deliver/requirements not yet fully known • WG funding process for future years still to be confirmed • Impact of national architecture and governance reviews not yet known.		Work with Capital finance an WG to agree resourcing arrangements. Work with CTM on the business case to implement boundary change disaggregation actions Sign off IMTP including project milestones.			

8. Enabling Objective: Outstanding Research, Innovation, and Education & Learning										
Principal Risk: Failure that the Health Board will not be able to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.										
Corporate Risks					**Unit Risks**					
• no risks identified					• no risks identified					
Executive Lead: Executive Medical Director					**Assuring Committee:** Quality and Safety Committee					
Key Controls	**Form of Assurance**	**Levels of Assurance**			**Gaps in Control**	**Gaps in Assurance**	**Actions Agreed for any gaps in control or assurance**	**Assurance**	**Current Risk Rating**	**Direction of Travel**
		1st	**2nd**	**3rd**						
8.1 <u>Research Portfolio</u> • Research & Development Committee • Board for Joint Research Facility • Integrated Medium Term Plan (IMTP)	• Updates to the Research & Development Committee & the Board for Joint Research Facility • Increase in the number of Health and Care Research Wales Clinical; Research Portfolio studies and commercially sponsored studies. • Increase in the number of participants recruited into Health and Care; Research Wales Clinical Research Portfolio studies and commercially sponsored studies.	▲	▲		None identified	None identified	tbc			
8.2 <u>Innovation Hub</u> • Integrated Medium Term Plan (IMTP) • Clinical Services Plan	• Awaiting information from Strategy team		▲		None identified	None identified	tbc			
8.3 Innovation Multi-Disciplinary Team (MDT) • Clinical Services Plan	• Business case to secure funding for developing the MDT.			▲	None identified	None identified	Submit business case to secure funding for developing the MDT.			
8.4 Undergraduate and Postgraduate Education • Annual Meeting with Health Education & Improvement Wales (HEIW) • Deanery visits	• Attending the HEIW annual meeting • Doctor experience feedback • GMC feedback • Feedback from Deanery visits	▲	▲	▲ ▲	None identified	None identified	tbc			

9. Enabling Objective: Embedding Effective Corporate Governance

Principal Risk: Failure to meet statutory obligations in relation to corporate governance, including health & safety, infection control, etc. which could result in breaches in standards and other failures leading to significant patient harm, financial penalties and regulatory intervention.

Corporate Risks	Unit Risks
• HBRR 13 – Environment of Health Board Premises • HBRR 41 - Fire Safety Regulation Compliance • HBRR 52 - Statutory Compliance • HBRR 53 – Compliance with Welsh Language Standards • HBRR 39 – IMTP Statutory Responsibility • HBRR 42 – Financial Plan	• 1417- Fire Security • 1935 – Failure to address changes to legislation and poor designer performance for existing cladding • 1653 – Impact of new Medical Device Regulations • 2058 – Project delivery – Transformation

Executive Lead: Director Of Corporate Governance | **Assuring Committee:** Health Board/Health & Safety Committee

Key Controls	Form of Assurance	Levels of Assurance 1st	2nd	3rd	Gaps in Control	Gaps in Assurance	Actions Agreed for any gaps in control or assurance	Assurance	Current Risk Rating	Direction of Travel

9.1 Health & Safety Standards
• Health & Safety Committee
• Health & Safety Operational group, supported by specialist sub groups
• Executive Lead for Health and Safety
• Health & Safety policies
• Health and safety risk assessments
• Datix incident reporting system
	• Regular reports to the Board and the Health and Safety Committee
	• Improvement Plan in place to address the HSE Improvement Plan
	• Regular reporting from Units through to the Health & Safety Operational Group
	• Health and Safety Annual Report
	• Health and safety risk register
	• Health & Safety Operational Group supported by specialist sub groups, e.g. water safety, asbestos etc.
	• H&S Datix alerts circulated
	• Policies and Procedures in place
	• Health and safety risk assessments
	• Incident reporting procedure
	• H&S intranet pages and newsletter
	• HSE inspections - On 14 October 2019 a letter was received from the HSE confirming that of the 10 improvement notices, 7 were complied with fully,
		▲		▲	**Health and Safety Improvement Notices**
					• 9 Health & Safety Executive (HSE) Improvement notices were received in February 2019 relating to violence & aggression, manual handling and the reporting and investigating of health & safety incidents
					• 1 Health & Safety Executive (HSE) Improvement notice was received in July 2019 relating to Vehicle and transport separation, change management, moving and handling and violence & aggression.
					• 3 x HSE notices given extension dates for compliance:
					  ○ AMO5 - Reporting and investigating health & safety incidents – **extension until 6 December 2019**
					  ○ JVH3 - Manual Handling, Theatre Department, Singleton Hospital – **extension until 6 December 2019**
					  ○ AMO4 - Manual Handling, Portering
							HSE improvement plan in place to address issues concerning violence and aggression, manual handling and incident reporting.
							
							Health and safety structure being reviewed.
							
							HSE CEO de-brief b8 November 2019.
							
							3 x HSE notices given extension dates for compliance:
							• AMO5 - Reporting and investigating health & safety incidents – **extension until 6 December 2019**
							• JVH3 - Manual Handling, Theatre Department, Singleton Hospital – **extension until**			

	with three receiving extensions to fully comply with the notices. • An interim Assistant Director of Health & Safety and an interim Head of Compliance post were appointed on secondment in May 2019 to support compliance requirements in relation to health & safety, quality governance and corporate governance.	▲			Staff, Morriston Hospital - **extension until 6 December 2019** • HSE inspection 10 October 2019 into electric shock incidents from the heating up of the regeneration catering trolleys resulted in 2 x additional HSE improvement notices: o IN/SWE/15/10/19/01 – Failure to ensure the low voltage electrical system (Morriston Hospital) – **date of compliance 6 December 2019** o IN/SWE/15/10/19/02 – Failure to appoint competent persons to assist in statutory provisions for supervisory or managerial positions to manage electrical safety (Morriston Hospital) – **date of compliance 31 January 2020** • HSE routine site inspection to visit Singleton Hospital 30 October 2019 as a follow up to new consents issued under the Ionising Radiation Regulation 2017 resulted in a breach notice. • **Human Tissue Authority (HTA)** - Inspection in June 2019 against the new HTA standards that were introduced in April 2017, resulted in a number of recommendations for improvement. • IA reports Estates Assurance: Control of		**6 December 2019** • AMO4 - Manual Handling, Portering Staff, Morriston Hospital - **extension until 6 December 2019**			

					Substances Hazardous to Health (COSHH) (ABM-1819-S12) – Limited Assurance • IA Report - Safe Water Management (ABM-1819-S09) – Limited Assurance					
9.2 Fire Safety • Health & Safety Committee • Health & Safety Operational group, supported by specialist sub groups • Fire safety risk assessments	• Regular reports to the Health and Safety Committee • Health & Safety Operational Group • Fire group • Policies and Procedures in place • Fire wardens • Fire evacuation tests • Fire safety training • Fire risk assessments • Incident reporting procedure • Fire risk assessments. • Evacuation plans (vertical and horizontal). • Fire safety training. • Professional advice sought on compliance of panels. • External inspections from the Fire & Rescue Service, HSE etc				• IA report Fire Safety (Follow up) (ABM-1819-009) IA report – Limited Assurance	South Wales Fire & Rescue Service (SWFRS) Enforcement Notice A Fire enforcement notice in respect of Dan-y-Bont Learning Disabilities Bungalow has been received following a site visit on Wednesday 14th August 2019.	Fire Cladding - Completion of Phases 1 replacement generator & phase 2 procurement of the replacement of sub-station 6 through Design 4 Life as part of Morriston Environmental Modernisations Programme. Full design of the New Road from M4 into Morriston Hospital to enable future development of services on site			
9.3 Financial Delivery Plan • Performance & Finance Committee • SBUHB Annual Plan/IMTP • Standing Orders • Standing Financial Instructions (SFI's) • Scheme of Delegation • Welsh Government NHS Wales Planning Framework 2019-2022[1] • Financial Reporting Manual • Capital Prioritisation Group • Investment and Benefit Group	• Detailed monthly monitoring returns submitted to Welsh Government • Regular reporting to Performance and Finance Committee and the Board • Monthly Budget Reports • Regular reports to Financial Management Group and Executive Board • SBUHB Annual Report incorporating performance report, corporate governance report (incl Annual Governance statement), staff and remuneration report and financial accounts • The Health Board has a number of established				IA report Board Assurance Framework (ABM-1819-006) attained a limited assurance rating in 2018-2019.	IA reports Charitable Funds: Part I (Wards) (ABM-1819-016a), Charitable Funds: Part II (Central Systems & Expenditure) (ABM-1819-016b) Charitable Funds: Golau Governance (Follow up) (ABM-1819-017) attained limited assurance ratings in 2018-2019.	Recovery & Sustainability - detailed plan for all but 3 work streams; plans in development urgently for remaining 3. Mitigating actions in place to counter balance these work streams. • NWSSP providing schedule of contracts and SHOs for each. • QVC 1 - meetings taken place with			

[1] https://gov.wales/sites/default/files/publications/2019-06/nhs-wales-planning-framework-2019-2022.pdf

	financial control measures including authorisation hierarchies, QVC panels and vacancy control panel. • The financial controls are being enhanced through the High Value Opportunity work streams. • Establishment of a Delivery Support Team will support and challenge on all aspects of financial performance including savings. The Delivery team will also support and ensure the development of a strong pipeline of schemes and opportunities. This team are likely to be supported by some External intervention support. • Agreed budget holders and budgetary control systems in place, financial control procedures including the scheme of delegation and Standing Financial Instructions • Approved Discretionary Capital Programme	▲	▲			IA report Systems (Risk Management / Declarations of Interest) (ABM-1819-S07) attained limited assurance rating in 2018-2019.	clinical cabinet and MD. Action: Delivery of Financial savings through delivery of the underlying deficit, management of cost pressures and delivery of high value opportunities. – Around 99% of the original savings plan has been identified, however there has been slippage of £0.5m in Q1. The need to generate additional savings to assist with this savings slippage, continuing operational pressures and the Bridgend diseconomies have been identified and work is now underway to provide detailed action and implementation plans. The required level of savings does not take account of the determination in relation to the Bridgend Financial Impact Assessment and this will need to be considered once the WG determination is known. The future plan and milestones will be updated and revised as the work to implement the financial plan continues.			

9.4 Integrated Medium Term Plan/Annual Plan • Welsh Government NHS Wales Planning Framework 2019-2022[2] • SBUHB Annual Plan • Financial Reporting Manual • Standing Orders • Standing Financial Instructions (SFI's) • Scheme of Delegation •	• Reports to the Health Board, Executive Board on a regular basis • Medium term plan with one-year deliverables will be submitted to Board for approval in January – including a balanced financial plan • SBUHB Annual Report incorporating performance report, corporate governance report, staff and remuneration report and financial accounts. • Transformation Programme including programme approach has been established. • Continuous planning through our Transformation Programme will work up detailed plans to submit an approvable IMTP in Summer 2019 • Executive Steering Group in place for development of medium term plan • Plans will be assured by the P&F Committee before presentation to Board				The Health Board does not have an approved Annual Plan	EIA in development for PFC assurance QIAs in development for joint PFC/Q&S assurance IA report Annual Plan: Delivery Framework (ABM-1819-010) attained a limited assurance rating in 2018-2019. IA report on Clinical Audit & Assurance (ABM-1819-022) attained limited assurance rating in 2018-2019. IA report on Mortality Reviews (Follow up) (ABM-1819-025) attained limited assurance rating in 2018-2019. IA repot Third Sector Commissioning (Follow up) (ABM-1819-047)	The need to generate additional savings to assist with this savings slippage, continuing operational pressures and the Bridgend diseconomies have been identified and work is now underway to provide detailed action and implementation plans. The required level of savings does not take account of the determination in relation to the Bridgend Financial Impact Assessment and this will need to be considered once the WG determination is known. The future plan and milestones will be updated and revised as the work to implement the financial plan continues.			
9.5 Facilities and Estates • Long-term Capital & Estates Strategy • Capital plan • Capital Programme Group	• Reports to the Health Board, Executive Board on a regular basis • Approved Discretionary Capital Programme •				IA report Environmental/ Infrastructure Modernisation Programme (ABM-1819-S05) attained limited assurance rating in 2018-2019.		Completion of Phases 1 replacement generator & phase 2 procurement of the replacement of sub-station 6 through Design 4 Life as part of Morriston Environmental Modernisations Programme. Full design of the New Road from M4 into Morriston Hospital to enable future development of services on site.			

[2] https://gov.wales/sites/default/files/publications/2019-06/nhs-wales-planning-framework-2019-2022.pdf

							Continued implementation of the 2019 / 2020 Ward Refresh Programme Ward A Morriston Hospital.			
9.6 Welsh Language Standards • Welsh Language Delivery Group • Welsh Language Standards Action plan • Welsh language policies and protocols • Welsh Language translation service	• Reports to the Health Board, Executive Board on a regular basis • Welsh Language Delivery Group (WLDG) meets quarterly, chaired by the Executive Medical Director • Close constructive working relationships are in place with the Welsh Language Commissioner's Office • Strong networks are in place with the NHS Wales Welsh Language Officers network to share good practice, inform learning and to develop Business intelligence. • Proactive communication and marketing activity is being undertaken across the Health Board to raise awareness of Welsh language compliance, customer service standards and training opportunities. • Working with NHS Wales Shared Services (NWSSP) to achieve compliance for workforce and recruitment standards. • Progress against the SBUHB Welsh Language Standards Action plan and the 'More Than Just Words', strategy is reported to our internal "Welsh Language Delivery Group", the Executive Board, the Welsh Language Commissioner and Welsh Government • Annual Report on compliance against the Welsh Language Standards/Scheme • Report on progress included in the Annual Plan report • Executive Lead identified for	▲ ▲ ▲ ▲	▲	▲ ▲ ▲	The self-assessment has confirmed that the Health Board is not able to fully comply with all the Standards and that the Health Board will need to take a risk management approach to the delivery of the standards. The Welsh Language Delivery Group is monitoring compliance against the WL action plan.	Ability of ESR to accurately record staff WL competency.	As of 31st December 2018 Abertawe Bro Morgannwg University Health Board now known as Swansea Bay University Health Board has made all out-patient appointment letters sent via the Welsh Patient Administration system bilingual. No new letters will be added to the system unless they are bilingual with contingency arrangements in place for any 'non-standard' text. The WLDG IT sub group is looking at strengthening bilingual IT processes. The SBUHB Bilingual Skills strategy is being reviewed by the workforce team and the WLDG to increase the focus on Welsh Language skills particularly for patient- facing roles. Welsh Language Improvement plan 2019-2020		15	

	Welsh Language • Appointment of additional Welsh Language translators • Self-assessment of the requirements of the new Welsh Language Standards and how they apply to SBUHB. • A Welsh Language Standards action plan has been devised to focus on strengthening and developing compliance in key areas.	▲ ▲ ▲								
9.7 DoLS Authorisation & Compliance with Legislation (HBRR43) • Mental Health Legislation Committee (MHLC) • Mental Capacity Act 2005 • Deprivation of Liberty Safeguards Code of Practice • DOLS action plan	• Reports to the Mental Health Legislation Committee • DOLS assessments Supervisory body signatories increased from 3 to 7 • HIW reports • 2 x substantive BIA posts and additional admin post advertised • DoLS database updated and DoLS dashboard devised to enable more accurate monitoring and reporting MHLC.	▲ ▲ ▲		▲ ▲	IA report Protection of Vulnerable Adults: Deprivation of Liberty Safeguards (Follow up) (ABM-1819-026) attained a limited assurance rating in 2018-2019.		Delivery of DOLS Action plan reviewed monthly			